0962: SURGICAL REFERRALS FROM NURSING HOMES; MORE EVIDENCE FOR A GERIATRIC MEDICINE LIAISON SERVICE

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Aims: To assess outcomes of inpatient stay in patients referred to acute surgical unit from residential homes, comparing with non-institutionalised patients with similar presenting complaints.
Methods: 40 patients admitted from homes over six months were matched with following emergency surgical admission living independently aged >70. Data gathered via 'take' lists and discharge summaries.
Results: Dementia was more prevalent in the residential care (45 vs. 28%), who also had more co-morbidities (4.4 vs. 2.6). Presenting complaints between groups were similar, abdominal pain and haematemesis being leading causes. Larger proportion of community residents underwent surgery during admission (28 vs. 5%) whilst greater proportion of residential care died during admission (15 vs. 2.5%). Residential care patients had a slightly longer average duration of stay in this study (5.5 vs 4.2 days).
Conclusions: Whilst presenting with similar complaints, residential care patients are less often surgical candidates; fewer undergo surgery and a larger proportion die during admission. This supports value of geriatric liaison, particularly discharge planning, including in those patients palliative needs, as well as medical optimisation of co-morbidities when surgery is considered. Presented to the surgical and elderly care department: a new admission pathway for this group of patients was proposed to the trust, suggesting refferal via the geriatric team.

1045: OUTCOMES FOLLOWING EMERGENCY GENERAL SURGERY IN NONAGENARIANS

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Aim: In 2010 NCEPOD highlighted concerns over outcomes of elderly patients undergoing emergency surgery. This study aimed to investigate outcomes in nonagenarians undergoing emergency surgery and identify predictive risk factors for mortality and the impact on care requirements.
Method: All nonagenarian patients who underwent emergency general surgery operations between June 2005 and June 2010 within one NHS Trust were retrospectively reviewed. Risk factors analysed included age, sex, ASA grade, clinical parameters, preoperative blood tests (including C-reactive protein (CRP)), preoperative care dependence, operation factors and surgeon factors. Kaplan-Meier survival analysis was performed using one year mortality rates.
Results: Forty six patients (30 female) underwent surgery with an inpatient mortality of 32.6% and one year mortality of 54.3%. Patients undergoing major index surgery, a CRP > 100 or who required any form of preoperative social care had significantly reduced survival (P= 0.013, P<0.001 and p=0.0024 respectively). Upon discharge 59.3 % of patient required no change in social care, 29.6% a temporary change and 11.1% a permanent change.
Conclusion: Emergency surgery in the nonagenarian is feasible with little long term change in social care requirements. Predictors of mortality are CRP >100, requirement for social care preoperatively and major index surgery.

1096: LAPAROSCOPIC APPENDICECTOMY – A NEGATIVE IMPACT ON EMERGENCY OPERATING?

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Background: Acute appendicitis is commonly managed with laparoscopic appendicectomy. However, there is a perception that it takes longer than an open operation and may, therefore, impact on the efficiency of emergency operating lists. The purpose of this study was to 1) evaluate the increase in laparoscopic appendicectomies over a five year period; 2) assess whether operating times are increased and 3) identify how this effects the provision of emergency operating lists.
Methods: Data was collected retrospectively for all appendicectomies performed in a single NHS trust from 2006 to 2011 and analysed over three time periods.
Results: The total number of appendicectomies performed annually ranged from 336 to 399. The percentage performed laparoscopically has progressively increased from 9% in 2006 to 56% in 2011. The average time taken to perform a laparoscopic appendicectomy was eight minutes longer than for an open procedure (p<0.001). The average duration of laparoscopic appendicectomy has not changed since 2006.
Conclusion: Although laparoscopic appendicectomies took consistently more time than open appendicectomies, the average difference was only eight minutes. Given the average number of appendicectomies performed per day is one, it is unlikely this increased operating time will negatively impact on the provision of emergency surgery.

1129: IS THE USE OF LAPAROSCOPY LEADING TO A RISE IN THE NEGATIVE APPENDICECTOMY?

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Aim: Studies have shown that negative appendicectomy rates are not significantly reducing and that laparoscopy is possibly lowering the threshold for intervention in patients with suspected appendicitis. Our aim was to establish the rate of negative appendicectomy in our instituion and identify related factors.
Methods: A retrospective review of patients undergoing an appendicectomy over 12 months was performed. Data on the pre-operative assessment, investigation, operative management and final pathology of patients were collected. Chi squared test was used to identify any factors associated with a negative appendicectomy.
Results: 95 patients underwent an appendicectomy. The median age was 30yrs. 51 (54%) of patients were male. 19% of patients underwent preoperative computed tomography (CT). 29 patients underwent open appendicectomy, 65 laparaoscopic and of these 6 were converted to open. Appendicitis was significantly more likely in patients undergoing open surgery compared with laparoscopic surgery (93% vs. 63%, p=0.004). Women were significantly more likely to undergo laparoscopy (78% vs 50%, p=0.02). 93% of patients with CT findings suggestive of appendicitis had appendicitis.
Conclusions: The use of laparoscopy appears to be associated with an increased rate of negative appendicectomy. Increased use of CT may be preferable to initial laparoscopy.

1177: THE EFFECT OF CENTRALISING THE TRAUMA SERVICE ON GENERAL SURGERY EMERGENCY OPERATIONS: CLOSING THE LOOP ON AN AUDIT OF TIME WAITING FOR SURGERY

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Aims: Following the centralisation of trauma services to a single unit there were concerns that this would increase pressure on emergency general surgery provision and theatre access. Therefore, time to theatre was audited before and after centralisation against guidelines set by the Royal College of Surgeons.
Methods: Data was collected from 471 patients: January-June 2009 before and January-June 2011 after the addition of the trauma unit. The waiting time from booking emergency general surgery to operation for admissions was audited using the theatre database
Results: The median waiting time was 6.6 hours (0.3-61.1) for procedures before trauma centralization compared with 12.5 hours (0.0-120.3) for procedures after trauma centralisation. For laparotomy, appendicectomy and incision and drainage of abscess waiting times were 3.6 hours (0.3-26.6), 5.7 hours (0.4-37.4) and 15.1 hours (0.4-61.1) respectively before centralization and 6.5 hours (2-39), 7.8 hours (0.7-58.3), and 16.7 hours (1.3-120.3) respectively following centralisation. 37% of appendicectomies breached the18-hour sepsis target following centralization compared with 17% prior to centralisation.
Conclusions: Centralisation of trauma services has resulted in increased waiting times for general surgery emergencies. Following this audit general emergency theatre provision has been increased and protected from other service demands.

UPPER-GASTROINTESTINAL SURGERY

0036: STOPPING PPIS PRIOR TO ENDOSCOPY

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